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No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY), ET AL., PETITIONERS

v.

WANDA GLENN

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTIONS PRESENTED

1. Whether an insurance company or other administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is operating under a conflict of interest that must be weighed on judicial review of a benefit determination.

2. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination.

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INTEREST OF THE UNITED STATES

This case concerns the standard a court should use to review a denial of plan benefits by an administrator of an employee benefit plan governed by Title I of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA to ensure fair and impartial plan administration and compliance with ERISA's requirements. At the invitation of the Court, the United States filed a brief as amicus curiae at the petition stage of this case.

STATEMENT

1. The Employee Retirement Income Security Act, 29 U.S.C. 1001 *et seq.*, was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). As part of its comprehensive enforcement scheme, ERISA authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B).

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court considered the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108. Noting that Congress did not specify a standard, the Court turned to the purposes of ERISA and its basis in trust law. *Id.* at 108-115. It concluded "that a denial of benefits * * * is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Ibid.* (quoting Restatement (Second) of Trusts § 187 cmt. d at 403 (1959) (Second Restatement)).

2. Respondent worked for Sears, Roebuck and Company (Sears) from 1986 until 2000. Pet. App. 2a-3a. She participated in a Sears-sponsored disability benefit plan governed by ERISA. J.A. 181a. The plan provided disability benefits in two stages. In the first stage, a person was totally disabled when she was unable to perform her regular job. Pet. App. 3a. In the second stage, which began after 24 months of benefits, an employee could continue receiving benefits only if she demonstrated that she was unable to perform "*any* gainful work" for which she was reasonably qualified. *Ibid.* The plan was both administered and insured by petitioner Metropolitan Life Insurance Company (MetLife), and the plan expressly gave MetLife discretionary authority to interpret its terms and determine entitlement to benefits. J.A. 181a-182a.

Respondent has a history of heart problems. In the early 1980s, she developed hypertension; in 1989, she experienced sudden cardiac death, was resuscitated, and was implanted with a defibrillator; and in the 1990s, she was diagnosed with left ventricular dysfunction and hospitalized twice. Pet. App. 4a. In 2000, her treating cardiologist, Dr. Rajendera Patel, diagnosed her with severe dilated cardiomyopathy, a condition in which the heart does not pump properly. *Id.* at 2a-3a; J.A. 89a-91a. Dr. Patel advised that respondent could not continue working at any job that entails "any significant physical or psychological stress." J.A. 82a. As a Sears sales manager, respondent supervised 20-30 employees, was required to stand or walk for most of the work day, and reported directly to the store's general manager. Pet. App. 2a-3a; J.A. 115a-117a.

Respondent stopped working and applied for disability benefits under the Sears plan. Pet. App. 3a. She

submitted a letter from Dr. Patel stating that she "has significant difficulty with general fatigue and exertional shortness of breath because of her cardiac condition" and "cannot return to any kind of job that would require any significant physical or psychologic demands on her." J.A. 88a. According to Dr. Patel, respondent's "main problem" was "the stress at work" that aggravated her cardiac condition. *Id.* at 82a. Dr. Patel also indicated, on a "statement of functional capacity" form provided by MetLife, that respondent was "totally disabled" with respect to her current occupation and "never" would be able to engage in any occupation. *Id.* at 109a-110a.

MetLife approved respondent's claim and began paying benefits. Pet. App. 3a. MetLife directed respondent to apply for Social Security disability benefits and referred her to a law firm to assist her in that process. *Ibid.* A Social Security Administration (SSA) administrative law judge determined that respondent was unable to perform her prior job or any job existing in significant numbers in the national economy and retroactively awarded her disability benefits. *Id.* at 46a-49a. MetLife reduced respondent's benefits and required her to reimburse it for past benefits. *Id.* at 3a-4a.

After paying benefits for 24 months, MetLife notified respondent that she could continue receiving benefits only if she was unable to perform "any gainful occupation." Pet. App. 3a-4a. Respondent submitted additional medical records, including a letter from Dr. Patel dated July 28, 2000, which stated that she still experienced "periods where she feels extremely tired and fatigued," despite some improvement "from the reduction of stress and strain of work." J.A. 84a-85a. In November 2000, June 2001, and December 2001, Dr. Patel completed statements of functional capacity for MetLife,

each time indicating that respondent was "totally disabled" and was "never" expected to resume work activities. *Id.* at 66a-70a, 77a-81a, 95a-99a.

In November 2001, Dr. Patel stated that respondent was "clinically stable," but he noted that she "still gets fatigued out and short of breath, particularly if she is under any kind of significant psychologic stress." Pet. App. 5a; J.A. 62a-63a. In March 2002, in a response to a request from MetLife, Dr. Patel checked a box on a form indicating that respondent "is able to work in a sedentary physical exertion level occupation." Pet. App. 5a-6a; J.A. 57a-58a. In a letter dated June 18, 2002, however, Dr. Patel stated that he "d[id] not believe that [respondent] will handle any kind of stress well at work" and concluded that she is disabled. Pet. App. 6a; J.A. 46a-47a.

MetLife reviewed these records and decided to cease paying benefits on the ground that respondent could perform sedentary work. J.A. 14a-15a. Respondent sought reconsideration. *Id.* at 35a. She submitted a July 2002 letter from Dr. Patel, which reiterated that he "d[id] not believe that [respondent] should be forced to return to any kind of even sedentary work particularly because it is the psychologic stress of work that really exacerbates her cardiovascular condition and symptomology." *Id.* at 44a-45a.

Nonetheless, in August 2002, MetLife denied respondent's disability claim, stating that "[t]here is no supportive medical documentation of the exacerbation of [her] condition and symptomology, due to subjective complaints of work-related stress." Pet. App. 7a; J.A. 29a-33a.

Respondent appealed the benefit denial and submitted an additional letter from Dr. Patel. Pet. App. 7a;

J.A. 41a-43a. In that letter, Dr. Patel reviewed respondent's medical history, explained that she cannot work because "[s]he has a cardiac problem that is exacerbated by any kind of stress," and again concluded that she is "completely disabled." Pet. App. 7a; J.A. 42a. Dr. Patel stated that, although "[p]revious reports filled out by me state that [respondent] was fit for sedentary work, * * * based on her clinical condition and her symptomology, there was never a time where I felt that [she] would be able to return to full-time employment." *Ibid.*

MetLife referred respondent's case to an independent physician, Dr. Chandrakant Pujara, who reviewed respondent's file but did not examine her. Pet. App. 8a; J.A. 37a-40a. Dr. Pujara stated that "[t]he actual impact of any form of real or perceived emotional stress on cardiac arrhytmias, or cardiomyopathy is difficult to gauge," but suggested that respondent "try one of the [recommended] sedentary job classes at least on a trial basis." Pet. App. 8a; J.A. 39a.[1] "If the job environment entails [a] significant degree of emotional stress," he concluded, "then certainly permanent disability can be considered." Pet. App. 8a; J.A. 39a.

MetLife issued a final denial of benefits. Pet. App. 8a; J.A. 23a-26a. It noted that Dr. Patel's June 2002 physical capacity evaluation stated that respondent "could sit for 8 hours, stand for 4 hours, and walk from 2-4 hours in an 8-hour workday" as long as there was "no emotional stress or heavy exertion"; that a certified rehabilitation counselor identified sedentary occupations

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[1] MetLife later acknowledged that respondent "had not been offered a part-time position at Sears" and "would have no chance of receiving benefits under the Sears ERISA plan if she went to work * * * for another employer on the trial basis that Dr. Pujara suggested." Pet. App. 18a n.2.

that respondent could perform consistent with those limitations; and that Dr. Pujara found respondent to be "relatively stable." J.A. 24a-25a. It also noted—but did not respond to—Dr. Patel's February 2003 statement that he "never felt that [respondent] could return to full-time employment." *Id.* at 25a. MetLife concluded, without further elaboration, that "the documentation currently in the file does not support a disability that would prevent [respondent] from performing any occupation." *Id.* at 25a-26a.

3. Respondent filed suit under 29 U.S.C. 1132(a)(1)(B), and the district court upheld MetLife's benefit denial. Pet. App. 27a-40a. The court applied an "arbitrary and capricious" standard of review because the plan "grant[ed] the administrator discretionary authority" to determine benefits. *Id.* at 32a-33a. However, because MetLife "both decides whether an employee is eligible for benefits and pays those benefits," the court concluded that "an actual conflict of interest exists" that "must be "weighed as a 'facto[r]'" in reviewing the benefit denial. *Id.* at 32a-34a (quoting *Firestone*, 489 U.S. at 115).

The district court then reviewed the medical evidence. Pet. App. 38a-40a. Relying on the March 2002 form in which Dr. Patel checked a box indicating that respondent was able to work and on Dr. Pujara's report, the court concluded that there was "substantial evidence supporting MetLife's determination that [respondent] was no longer totally disabled." *Id.* at 37a-40a. The court noted that MetLife had not considered the award of Social Security disability benefits, but it rejected respondent's contention that the award substantiated her disability. *Id.* at 36a.

4. The court of appeals reversed and reinstated respondent's benefits. Pet. App. 1a-26a. Like the district court, it utilized "arbitrary and capricious" review because the plan granted MetLife discretionary authority to determine benefits. *Id.* at 9a. The court held, however, that MetLife was operating under an "apparent conflict of interest" because it was "authorized both to decide whether an employee is eligible for benefits and to pay those benefits," and it concluded that the district court failed to give that conflict "appropriate consideration." *Id.* at 10a.

The court of appeals also determined that the district court gave "inadequate consideration" to MetLife's failure to address the award of Social Security disability benefits, particularly in light of the fact that MetLife "had encouraged and assisted [respondent] in obtaining Social Security disability benefits" and "benefitted financially from the government's determination that [respondent] was totally disabled." Pet. App. 10a, 14a-15a. The court noted that although the Social Security award "certainly [was] not binding," it was "far from meaningless," and MetLife's failure to even consider it is "a significant factor to be considered upon review." *Id.* at 15a (internal quotation marks omitted).

The court of appeals then reviewed the medical evidence, noting MetLife's "persistent failure to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe [respondent] was capable of returning to work, sedentary or otherwise." Pet. App. 15a-16a. Instead, it placed "heavy reliance" on the "aberrational" March 2002 form in which Dr. Patel checked a box suggesting respondent could work. *Ibid.* The court explained that, although MetLife was not required to "accord special

deference to the opinion of [respondent's] treating physician," "it may not arbitrarily repudiate or refuse to consider" it. *Id.* at 19a. The court also noted MetLife's reliance on the opinion of Dr. Pujara, who did not examine respondent and did not appear to have considered Dr. Patel's key reports. *Id.* at 18a-19a. Finally, it noted that MetLife ignored the "consistent and repeated references by Dr. Patel to stress as a factor in [respondent's] condition," in concluding without explanation that "no supportive medical documentation" indicates that stress exacerbates respondent's condition. *Id.* at 21a-22a.

The court of appeals concluded that MetLife's "inappropriately selective consideration of [respondent's] medical record," combined with its conflict of interest and its failure even to acknowledge the Social Security disability benefits award, led to a benefit denial that "can only be described as arbitrary and capricious." Pet. App. 25a.

SUMMARY OF ARGUMENT

As this Court recognized in *Firestone*, Congress did not specify a standard of review when it authorized federal courts to review claims for benefits in 29 U.S.C. 1132(a)(1)(B). As a result, the Court turned to principles of trust law and concluded that courts should review benefit determinations *de novo*, except in the case of an ERISA plan that confers discretion upon the plan administrator to interpret plan terms and make benefit determinations, in which case abuse-of-discretion review applies. In the case of a plan administrator that is entrusted to make discretionary determinations but is operating under a conflict of interest, the Court suggested that the conflict is to be "weighed as a factor" in review-

ing the benefit determination for an abuse of discretion. This case presents that set of facts, because MetLife is a plan administrator that has discretion to make benefit determinations under the terms of the Sears ERISA plan and is required to pay any claims it finds have merit.

An ERISA plan administrator that both makes benefit determinations and pays benefits out of its own funds, such as MetLife, is operating under a conflict of interest, because it benefits financially if it denies an employee's claim. That common-sense understanding of what constitutes a conflict of interest is supported by numerous examples from the law of trusts and is consistent with this Court's recognition of the competing pressures on dual-role administrators in *Firestone*. Rather than seriously dispute the existence of a conflict of interest, MetLife proffers numerous reasons why courts should turn a blind eye to the administrator's self-interest in reviewing benefit determinations. None is persuasive. A court reviewing a benefit determination by a dual-role administrator should consider the administrator's conflict of interest, even in the absence of evidence indicating that the administrator was motivated by its financial self-interest.

Further, as this Court recognized in *Firestone*, a court reviewing a benefit determination by a dual-role administrator should weigh the conflict of interest as a factor in abuse-of-discretion review. That is to say, a court should take extra care to ensure that the plan administrator's decision was reasonable, taking into account all of the relevant facts and circumstances, including the conflict of interest. That standard of review, which derives from trust law, provides the proper balance between an employer's right to set up an ERISA

plan as it sees fit and a participant or beneficiary's entitlement to an impartial benefit determination. Moreover, that context-specific standard provides courts with the needed flexibility to satisfy themselves that a plan administrator's conflict of interest did not lead to an improper denial of benefits.

The Sixth Circuit thus correctly held that MetLife's dual roles as an administrator and insurer of benefits created a conflict of interest that should be taken into account in a review of its benefit denial. Moreover, the Sixth Circuit correctly weighed all of the relevant circumstances under abuse-of-discretion review to conclude that MetLife's benefit denial was unreasonable.

ARGUMENT

AN ERISA PLAN ADMINISTRATOR THAT BOTH PAYS CLAIMS AND MAKES BENEFIT DETERMINATIONS IS OPERATING UNDER A CONFLICT OF INTEREST THAT SHOULD BE WEIGHED AS A FACTOR IN DETERMINING THE REASONABLENESS OF A BENEFIT DETERMINATION

A. An Administrator's Dual Role Constitutes A Conflict Of Interest That Should Be Taken Into Account In A Suit For Benefits

1. A plan administrator that both decides claims and pays benefits from its own funds (*i.e.*, a dual-role administrator) has a conflict of interest under the plain meaning of that phrase. A "conflict of interest" is a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." *Black's Law Dictionary* 319 (8th ed. 2004). In the ERISA context, a dual-role plan administrator operates under a conflict of interest because it has fiduciary duties to plan participants and beneficiaries to pay meritorious claims, 29 U.S.C. 1104(a)(1)(A) and (B), while having a private

profit-making interest that is furthered by denying claims. See, *e.g.*, *Killian* v. *Healthsource Provident Adm'rs, Inc.*, 152 F.3d 514, 521 (6th Cir. 1998) (dual-role plan administrator "incurs a direct expense as a result of the allowance of benefits," and "benefits directly from the denial or discontinuation of benefits"); *McGraw* v. *Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1259 (10th Cir. 1998) (for a dual-role administrator, "every exercise of discretion impacts [the administrator] financially, filling or depleting its coffers"). Particularly in "the insurance-company-as-funder-and-administrator context, the fund from which monies are paid is the same fund from which the insurance company reaps its profits." *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000).

Trust law likewise recognizes that a trustee has a conflict of interest when its own financial interests have the potential to conflict with the interests of trust beneficiaries. For example, when a trustee is also "a beneficiary of the trust," "a certain conflict of interest undeniably results." See, *e.g.*, *Gregory* v. *Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979). Similarly, a "trustee occupies a conflict-of-interest position * * * where he is or may be a successor or remainderman of a substantial portion of the trust estate, particularly where his actions preserve or enhance the value of the succession." *Dowdy* v. *Jordan*, 196 S.E.2d 160, 164 (Ga. Ct. App. 1973). In those situations, there may be a question as to whether that conflict of interest actually influenced the trustee's decisionmaking, but it cannot be denied that a conflict exists. See, *e.g.*, George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 543, at 244-245 (rev. 2d ed. 1993) (when a trustee "has an interest which conflicts with that of the trust beneficiaries," he

"cannot prevent the existence of the conflict of interest," but he may be able to minimize its impact or remove it).

There can be no serious dispute on this point. Although some courts have declined to weigh a dual-role administrator's conflict of interest as a factor in judicial review of a benefit determination, they typically have not denied the *existence* of the administrator's competing interest. Rather, they have determined that the conflict should not be given weight because, in their view, there are countervailing factors that prevent the administrator from acting in its own interest. See, *e.g.*, *Pari-Fasano* v. *ITT Hartford Life & Accident Ins. Co.*, 230 F.3d 415, 418 (1st Cir. 2000) ("an insurer does have a conflict of sorts when a finding of eligibility means that the insurer will have to pay benefits out of its own pocket"). Petitioners, too, do not deny the *fact* of the conflict of interest; they instead argue that it should not be given weight on judicial review. Pet. Br. 21-40. But petitioners' view is inconsistent with the trust law principles that guide interpretation of ERISA.

2. As this Court recognized in *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 109 (1989), although Congress authorized ERISA participants and beneficiaries to sue to recover benefits under the plan, it "d[id] not set out the appropriate standard of review for [such] actions." Because "ERISA abounds with the language and terminology of trust law," the Court determined that it should be "guided by principles of trust law" in "determining the appropriate standard of review." *Id.* at 110-111; see *Central States, Se. & Sw. Areas Pension Fund* v. *Central Transp., Inc.*, 472 U.S. 559, 570 (1985). Trust law counsels that a dual-role plan administrator operates under a conflict of interest that reviewing courts should not ignore.

a. Under settled principles of trust law, courts routinely consider a trustee's conflict of interest in reviewing the propriety of his decisions. As an initial matter, trust law to a significant extent restricts self-interested parties, such as the beneficiaries of a trust, from even being appointed as trustees. Trust law places an exacting duty of loyalty upon a trustee: the trustee must "administer the trust solely in the interest of the beneficiaries," and "is strictly prohibited from engaging in transactions that involve self-dealing or that otherwise involve or create a conflict between the trustee's fiduciary duties and personal interests." Restatement (Third) of Trusts § 78(1) and (2) at 93-94 (2007) (Third Restatement).

If a settlor chooses to appoint a self-interested person as a trustee, however, "the existence of conflicting interests is not ordinarily" a sufficient basis for a court to refuse to honor that choice. Third Restatement § 32 cmt b at 104. Yet courts do not ignore the trustee's resulting conflict of interest. Instead, "when a beneficiary serves as trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*," even in the absence of evidence that the trustee acted in his own self-interest. *Id.* § 37 cmt. f(1) at 137 (emphasis added).

Courts have routinely applied the principle that a trustee's financial self-interest must be considered upon judicial review of his conduct. See, *e.g.*, *Garvey* v. *Garvey*, 22 N.E. 889, 890 (Mass. 1889) (review of actions of trustee who was also remainderman must consider "the influence of a pecuniary interest to withhold from plaintiff any benefit or assistance from said trust"); *In re Peabody's Will*, 96 N.Y.S.2d 556, 562 (Sup. Ct.), aff'd,

98 N.Y.S.2d 614 (App. Div. 1950) (when trustee is also beneficiary and remainderman, his "conduct * * * in the administration of the trust will be subject to careful scrutiny"). Courts do not require evidence that the trustee actually acted with improper motive before considering his conflict of interest. See, *e.g.*, *Fulton Nat'l Bank* v. *Tate*, 363 F.2d 562, 571 (5th Cir. 1966) ("the beneficiary need only show that the fiduciary allowed himself to be placed in a position where his personal interest might conflict with the interest of the beneficiary"; "[i]t is unnecessary to show that the fiduciary succumbed to this temptation").

b. In the ERISA context, as in trust law, a dual-role plan administrator's conflict of interest is a factor that should be considered upon judicial review of its benefit decision. ERISA, like traditional trust law, imposes strict fiduciary duties of loyalty, prudence, and care on plan administrators. 29 U.S.C. 1104(a)(1)(A) and (B). Those duties cannot be waived. 29 U.S.C. 1110(a); see, *e.g.*, *Central States*, 472 U.S. at 568 ("trust documents cannot excuse trustees from their duties under ERISA").

Further, in ERISA, as in trust law, plan administrators may operate under certain conflicts of interest. In particular, a plan administrator may both decide benefit claims and pay those claims. See 29 U.S.C. 1102(c), 1108(c)(3). But that explicit authorization highlights the fact that it is a departure from general trust-law principles to permit an entity with such a conflict to serve as trustee.

Because ERISA incorporates key features of the law of trusts—including a trustee's fiduciary duties and the principle that conflicted fiduciaries may serve only in limited, expressly authorized circumstances—courts

should review a dual-role ERISA plan administrator's decision as they would review the decision of a self-interested trustee. When a plan administrator both makes benefit determinations and pays any benefits due, the administrator's benefit determinations should be subject to "careful scrutiny," even in the absence of specific evidence indicating that the administrator was influenced by its financial interest in the particular instance. Third Restatement § 37 cmt. f(1) at 137.

Indeed, trust law contemplates a situation similar to that of a dual-role ERISA plan administrator. The Second Restatement of Trusts addresses the example of a trustee who must pay "the income and so much of the principal as in his discretion shall be necessary for the support and comfort" of the beneficiary and then will obtain whatever property is remaining upon the beneficiary's death. § 107 cmt. f, illus. 1 at 237. That trustee, the Second Restatement explains, has a "conflicting interest" that requires his conduct to "be subject to careful scrutiny" when a court considers whether he failed to pay sufficient funds to the beneficiary. *Id.* at 236-237. The same should be true under ERISA: because a plan administrator is better off financially when it does not pay benefits, a court reviewing its benefit decisions should be cognizant of the administrator's financial self-interest. To require a court to do otherwise, as petitioners propose, would be to require it to turn a blind eye to a conflict that indisputably exists, and would undermine the integrity of the ERISA regulatory regime.

c. Consideration of a dual-role administrator's financial self-interest even without specific evidence suggesting the conflict influenced benefit decisions also comports with common sense, because "[a] conflicted fiduciary may favor, consciously *or unconsciously*, its inter-

ests over the interests of the plan beneficiaries." *Brown* v. *Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990) (emphasis added). Moreover, the perception that self-interest could creep into the benefit determination process even in subtle ways can undermine confidence in the fairness of the decisionmaking. Applying an added degree of scrutiny to such decisions is an effective counterweight that can enhance confidence in the integrity of the system.

Moreover, such a rule best comports with ERISA's purposes of "promot[ing] the interests of employees and their beneficiaries in employee benefit plans," *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983), "protect[ing] contractually defined benefits," *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985), and "providing for appropriate remedies, sanctions, and ready access to the Federal courts," 29 U.S.C. 1001(b). Congress imposed strict standards of loyalty and care to "specifically insulate the trust from the employer's interest." *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 333 (1981); see 29 U.S.C. 1104(a). "Congress intended in particular to prevent trustees 'from engaging in actions where there would be a conflict of interest with the fund.'" *Amax Coal Co.*, 453 U.S. at 333-334 (quoting S. Rep. No. 383, 93d Cong., 1st Sess. 31-32 (1973)). When an insurer or other plan administrator is nevertheless permitted to engage in such actions, courts should carefully scrutinize them to guard against the possibility that the administrator acted in its own self-interest to deny benefits improperly.

d. The result dictated by trust law and the purposes of ERISA has been foreshadowed by several of this Court's decisions. In *Firestone*, this Court noted that additional scrutiny is warranted in the case of a con-

flicted fiduciary: while "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers," 489 U.S. at 111, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion,'" *id.* at 115 (citing Second Restatement § 187 cmt. d).

This Court has reiterated its concern about the impartiality of dual-role administrators in two recent cases. In *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), the Court considered whether medical treatment decisions made by physicians in a health maintenance organization are fiduciary acts under ERISA. *Id.* at 214. In concluding that they are not, the Court recognized that, where a true fiduciary has a financial stake in the claims decision, "fiduciary capacity [i]s necessarily compromised." *Id.* at 227. More recently, in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), this Court found that a state statute regulating health maintenance organizations was not preempted by ERISA. *Id.* at 364-385. In reaching that conclusion, the Court stated its expectation that review of an administrator's benefit decision "for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised." *Id.* at 384 n.15. This case squarely presents the situation anticipated by the Court, and the Court should hold, consistent with its previous decisions, that a dual-role administrator operates under a conflict of interest that must be considered upon judicial review of a benefit determination.

3. Petitioners proffer several reasons why a court reviewing a benefit decision should ignore a dual-role administrator's conflict of interest. None is persuasive.

a. Contrary to petitioners' contention (Br. 21-23), the text of ERISA does not resolve the matter. Although ERISA permits plan funders to serve as claims administrators, see 29 U.S.C. 1102(c), 1108(c)(3), that authorization does not preclude an appropriately searching review of those administrators' decisions, for Congress left to the federal courts (guided by principles of trust law) the question of how they are to review administrators' decisions, including decisions by dual-role administrators. See *Firestone*, 489 U.S. 108-111; see also *Rush Prudential HMO*, 536 U.S. at 384-386. In fact, to the extent ERISA speaks to the issue, it suggests that a conflicted plan administrator's decisions should be carefully scrutinized, rather than insulated from meaningful judicial review, because ERISA imposes exacting fiduciary duties upon plan administrators and permits certain conflicts of interest only as exceptions to a general rule that such conflicts are not permitted. See pp. 15-16, *supra*; see also *Russell*, 473 U.S. at 142-143 (noting that "the avoidance of conflicts of interest" is among the primary statutory duties imposed by ERISA on fiduciaries).

b. Petitioners are likewise incorrect in contending (Br. 26-27) that courts should ignore a dual-role administrator's financial self-interest because a reviewing court's mere consideration of that factor would increase litigation. That contention is debatable as a matter of theory and lacks any empirical support. It also ignores Congress's overriding desire to protect plan participants and beneficiaries from self-interested fiduciaries. See p. 17, *supra*. Indeed, the *Firestone* Court rejected the argument petitioners now make, explaining that "the threat of increased litigation is not sufficient" to abandon the default *de novo* standard of review, which is

most consistent with settled principles of trust law and with ERISA's purposes. 489 U.S. at 114-115.

c. Petitioners also contend (Br. 29-33) that "the practical realties of the insurance business impose significant checks" upon them. There is no doubt some truth to this point, and it presumably explains Congress's willingness to countenance the conflict of interest in the first place. But it is not a basis for wholly ignoring the administrator's self-interest. And to the extent there are specific reasons to doubt that a conflict had any effect in a particular case, a court is free to consider such factors in its review for reasonableness. See p. 28, *infra*.

First, petitioners argue (Br. 29-30) that insurance companies have "reputational incentives" that will counteract their inherent conflict of interest. But while that is true, insurance companies' "reputational incentives" run in more than one direction, as they have incentives to keep costs down so that they can offer attractive rates to companies. See, *e.g.*, *Pinto*, 214 F.3d at 388 ("insurance carriers have an active incentive to deny close claims in order to keep costs down and keep themselves competitive so that companies will choose them as their insurers"). Moreover, there are limits to how much information employees will have and thus limits on the "reputational incentives" vis-a-vis employees. "Employees typically do not have access to information about claim-denying by insurance companies," especially because "many claims for benefits are made after individuals have left active employment." *Ibid.*

Second, petitioners contend (Br. 31-32) that an administrator's "employees who actually make benefit determinations do not have direct personal stakes in the outcome of their decisions." See BCBS Br. 14-15. The fact that there may be several layers in the principal-agent

relationship may distinguish the classic context of a single trustee with a conflict of interest, but it does not eliminate the conflict. It seems unrealistic that employees of the administrator would ignore the financial interests of their principal altogether. And courts and commentators have compiled ample evidence that insurance companies have reinforced that natural tendency by giving employees incentives to deny claims. See, *e.g.*, *Armstrong* v. *Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997) ("Apparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers based on criteria that include a category called 'claims savings.'"); John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1317-1321 (2007) (giving numerous examples of Unum/Provident's "cost containment measures that pressured claims-processing employees to deny valid claims"). Petitioners are also mistaken in comparing (Br. 31-33) the incentives of insurance company claims administrators to those of federal administrative law judges or prosecutors, most obviously because the federal government itself, unlike an insurance company, is not a for-profit institution. Cf. *Schweiker* v. *McClure*, 456 U.S. 188, 196-197 (1982).

Petitioners' amici argue (ACLI Br. 6; BCBS Br. 11-12) that any one individual claim has a minimal impact on the annual operating budget of a large insurance company such as petitioner. But increases in scale do not eliminate conflicts of interest. Because profits are made from claims decisions in the aggregate, "[o]ver time, a predilection to deny coverage pays well, even for inexpensive and infrequent treatments." *Carolina Care*

Plan, Inc. v. *McKenzie*, 467 F.3d 383, 387 (4th Cir. 2006).

Finally, petitioners argue (Br. 34-39) that federal and state regulators will adequately protect plan participants and beneficiaries. That contention cannot be squared with Congress's decision to provide, in *addition* to state and federal regulation, a civil cause of action for a participant or beneficiary to sue "to recover benefits due to him under the terms of his plan," 29 U.S.C. 1132(a)(1)(B). Although the Secretary of Labor has the authority to enforce fiduciary duties, see Pet. Br. 38-39, *only* a participant or beneficiary may bring a claim for benefits under 29 U.S.C. 1132(a)(1)(B), which makes the courts' role even more important in ensuring that administrators pay benefits due. Moreover, the extensive regulation of insurance companies by States is premised on the judgment that *increased* scrutiny generally is required "to prevent abusive practices—for example, false sales illustrations or failure to pay legitimate claims on a timely basis—that take unfair advantage of consumers." Robert W. Klein, *Insurance Regulation in Transition*, 62 J. Risk & Ins. 373, 374 (1995); see Langbein, *supra*, at 1340 (detailing such practices by Unum/Provident). There is thus ample reason for courts to acknowledge and weigh a dual-role administrator's conflict of interest.

B. A Benefit Denial By A Dual-Role Administrator That Has Been Granted Discretionary Authority To Determine Benefit Claims Should Be Reviewed For Reasonableness Under The Totality Of The Circumstances

1. Under settled principles of trust law, a court reviewing a discretionary decision of a self-interested trustee considers the conflict of interest as one factor in

determining whether the trustee's decision was reasonable. Some trustee powers and duties are "mandatory," in that they are "directed by the terms of the trust or compelled by the trustee's fiduciary duties," and others are "discretionary," meaning that the trustee "is to use fiduciary judgment." Third Restatement § 87 cmt. a at 242. When "discretion is conferred upon" a trustee "with respect to the exercise of a power," its exercise is subject to review for "an abuse * * * of his discretion." Second Restatement § 187 & cmt. d at 402-403; see Third Restatement § 87 & cmt. b at 242-243. In applying abuse-of-discretion review, courts apply "'a general standard of reasonableness,'" where "judicial intervention on the ground of abuse is called for, not because the court would have exercised the discretion differently, but because the trustee's decision is one that would not be accepted as reasonable by persons of prudence." Third Restatement § 87 cmt. c at 244-245.

In assessing the reasonableness of the trustee's decision—whether in interpreting the relevant instruments, making factual determinations, or exercising judgment in other respects—one relevant factor is "the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries." Second Restatement § 187 & cmt. d at 402-403; see 3 Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 187 at 15 (4th ed. 1988) (same). When a "conflict-of-interest situation[] exist[s], the conduct of the trustee in the administration of the trust will be subject to especially careful scrutiny." Third Restatement § 37 cmt. f(1) at 137.

2. Utilizing those trust-law principles, this Court in *Firestone* established the basic framework for how a conflict of interest should be taken into account in a suit

for benefits. The Court first concluded that courts should generally review benefit decisions *de novo*. 489 U.S. at 115. But it recognized that ERISA generally permits employers, like settlors under private trust law, to set up plans as they see fit, within the general parameters of the Act, see, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 444 (1999), and to grant discretion to plan administrators to interpret plan terms and determine claimants' eligibility for benefits. *Firestone*, 489 U.S. at 115; see 29 U.S.C. 1108(c)(3). ERISA also permits an employer to establish a welfare benefit plan "through the purchase of insurance." 29 U.S.C. 1002(1). A plan sponsor thus could reasonably choose to give discretionary authority for claims administration to an insurance company, notwithstanding its conflict of interest as the ultimate payor of benefits, in light of the cost of alternative arrangements, the insurer's expertise in administering and resolving claims, and the insurance company's past claims history. Where the sponsor has expressly chosen to give the insurer discretion to interpret plan terms or determine eligibility for benefits, review of those decisions applying the abuse-of-discretion standard—under which the decisions "will not be disturbed if reasonable," *Firestone*, 489 U.S. at 111—is the logical starting point because it best comports with the contractual and trust-law underpinnings of ERISA. See *id.* at 110-115; see also Third Restatement § 87 cmt. b at 243 ("A court will not interfere with a trustee's exercise of a discretionary power * * * when that conduct is reasonable.").

At the same time, ERISA mandates that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries," 29 U.S.C. 1104(a)(1), which incorporates the traditional duty of

loyalty of a trustee, see Third Restatement § 79 at 127. Accordingly, the very principles of trust law that call for review of discretionary decisions under a general standard of reasonableness also counsel that a plan administrator's conflict of interest must be weighed as a factor under that standard, as this Court also recognized in *Firestone*. See 489 U.S. at 115. Specifically, the existence of a conflict of interest requires a reviewing court to take extra care to ensure that the benefit determination was reasonable.

This flexible standard of review best balances ERISA's requirements of fiduciary loyalty, 29 U.S.C. 1104(a)(1), and "full and fair" review of benefit claims, 29 U.S.C. 1133(2); see 29 C.F.R. 2560.503-1(g), (h) and (j), with the statutory authorization for fiduciaries to serve in dual roles, 29 U.S.C. 1108(c)(3), and for employers generally to set up plans as they see fit, including through the purchase of insurance. This approach neither assumes that every administrator with a conflict of interest resolves disputes in a biased manner, nor uncritically defers to the administrator's judgment as if the conflict did not exist. Review under the general standard of reasonableness simply requires that the court's review be as searching of the administrator's decision as the facts and circumstances—including the existence of a conflict of interest—warrant. See *Woo* v. *Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998).

3. Neither more searching review nor more lenient review would be appropriate. Because the discretionary decisions of trustees are reviewed for an abuse of discretion (unreasonableness) even when they operate under conflicts of interest under trust law, see pp. 14-15, *supra*, and because the *Firestone* Court declined to rest its general rule of *de novo* review on the existence of an

underlying conflict of interest, 489 U.S. at 115, *de novo* review should not be required where the plan vests discretionary authority in an administrator that also pays benefits. Rather, the existence and nature of a conflict of interest should be taken into account as *part of* traditional review for reasonableness.

Nor is there any reason to shift the burden of proof to the plan administrator to establish that he was untainted by the conflict. Such an approach lacks any basis in the law of trusts, and it would complicate judicial review unnecessarily by diverting the court's attention away from the ultimate question in the case, which is the overall reasonableness of the plan administrator's benefit decision. See, e.g., *Doyle* v. *Liberty Life Assurance Co.*, 511 F.3d 1336, 1344-1346 (11th Cir. 2008).

At the same time, there is no basis in ERISA or the law of trusts for categorically giving a dual-role administrator's conflict of interest only "*de minimis* weight" (Pet. Br. 41). To do so would be to disregard trust law's concern about conflicted fiduciaries and Congress's intention that courts protect ERISA participants and beneficiaries from self-interested administrators. See pp. 14-17, *supra*.

4. The majority of courts therefore have correctly concluded that "[a]buse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest," but that review must be "informed by" the administrator's conflict of interest. *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 965, 967 (9th Cir. 2006).[2] Under that approach, a court should dis

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[2] Some courts have described this type of review as abuse-of-discretion review on a "sliding scale," while others reject that metaphor but use essentially the same approach. Regardless of whether the sliding scale metaphor is helpful, the United States agrees with the

agree with a plan administrator's decision only if it is unreasonable in light of all of the facts and circumstances. *Pinto*, 214 F.3d at 392 (approach "allows each case to be examined on its facts"). Courts may not overturn a "reasonable claim determination * * * simply because record evidence supports both sides of the issue," Pet. Br. 28, but they should take extra care to ensure that the administrator's determination was reasonable when there are factors that both undermine the objective soundness of the determination and at the same time suggest that the plan administrator might have been influenced by its conflict of interest.

For example, the existence of a conflict of interest should cause a court reviewing for reasonableness to give added scrutiny when an administrator: (1) "provides inconsistent reasons for [the benefit] denial," *Abatie*, 458 F.3d at 968-969; (2) "fails adequately to investigate a claim or ask the plaintiff for necessary evidence," *ibid.*; (3) "fails to credit a claimant's reliable evidence," *ibid.*; (4) "has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record, *ibid.*; (5) "revers[es] its own initial determination" that the claimant qualified for benefits, *Pinto*, 214 F.3d at 393-394; (6) reviews the claimant's evidence with "a selectivity that appears self-serving," by, for example, "credit[ing] one part of the advice of a treating doctor, but not his other advice," *ibid.*; or (7) intervenes on the claimant's behalf in administrative appeals to obtain finding of disability, then concludes

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approach of the majority of courts, which accounts for the structural conflict inherent in dual-role administration by giving a close look to the reasonableness of a conflicted administrator's decision in light of the process, rationale, and underlying evidence. See pp. 26-31, *supra*.

she is not disabled, *Ladd* v. *ITT Corp*, 148 F.3d 753, 755-756 (7th Cir. 1998). The court could also consider the "financial arrangement between the insurer and the company." *Pinto*, 214 F.3d at 392.

In addition, concern would be raised if there is evidence suggesting that the administrator denied the claimant full and fair review of his claim, as guaranteed by statute and by the Department of Labor's claims regulations, see 29 U.S.C. 1133(2); 29 C.F.R. 2560.503-1(g), (h) and (j), although such a defect may well constitute an independent ground for setting aside an administrator's decision. See *Abatie*, 458 F.3d at 972-973. Further, an administrator, facing closer scrutiny, might find it advisable to demonstrate that it has taken measures to mitigate conflict concerns, through the use of truly independent medical examiners or by ensuring that its claims reviewers do not have incentives to deny claims. See *id.* at 969 & n.7.

Moreover, the increased scrutiny cannot lose sight of the source of the conflict of interest. The point is not that dual-role administrators are generally less capable of making benefit determinations, but that there are potential financial incentives to skew decisions. Accordingly, in a dispute about benefits where the two alternative differ in respects other than costs (such as determining which of two individuals is the beneficiary under a life insurance policy), a financial conflict of interest would not be a relevant factor. Conversely, in a case like this involving a permanent disability determination, the significant dollar value of the benefit stream over time makes more focused review appropriate.

Under the proper approach, reviewing courts may take extra care to satisfy themselves that an inherent conflict of interest does not affect a benefit determina-

tion, without being required to undertake *de novo* review or burden-shifting. See *Chambers* v. *Family Health Plan Corp.*, 100 F.3d 818, 827 (10th Cir. 1996). Indeed, reasonableness review that permits courts to take a close look at benefit determinations is especially appropriate here, to permit the full "consideration of unique factors that are little susceptible * * * of useful generalization," *Cooter & Gell* v. *Hartmarx Corp.*, 496 U.S. 384, 404 (1990) (internal quotation marks omitted), such as the various factors identified above that both diminish the objective persuasiveness of the administrator's decision in its own right and at the same time could reflect a departure from the care, prudence, and rigorous attention to the duty of loyalty to participants and beneficiaries that are necessary to avoid decisions that are based upon the plan administrator's self-interest. In this context, as in many others, "[t]he deference that is due depends on the nature of the question presented," *Koon* v. *United States*, 518 U.S. 81, 98 (1996), and the tailored abuse-of-discretion review utilized by the majority of circuits provides the best way to "weigh" a conflict of interest in review of a benefit determination. See *Abatie*, 458 F.3d at 969 ("trial courts are familiar with the process of weighing a conflict of interest"). And any effort to articulate more precise standards or rules would likely prove to be unhelpful and even counterproductive, by introducing rigidity or artificiality into a process that ultimately calls for the exercise of sound judicial judgment of the sort that courts of equity traditionally have exercised in trust cases.[3]

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[3] Some courts have equated abuse-of-discretion review and "arbitrary and capricious" review and held, under the latter, that the court need only be satisfied that "substantial evidence" supports the plan administrator's decision. *E.g.*, *Wright* v. *R.R. Donnelley & Sons*

A plan's delegation of discretionary authority to interpret plan terms or decide coverage or eligibility questions is not a license to deny in practice what the plan promises in principle. Even when operating under a grant of discretion, the decisionmaker at each level of administrative review owes the participant an impartial determination guided by the terms of the plan as applied to the facts presented and the Secretary's claims pro-

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Co. Group Benefits Plan, 402 F.3d 67, 73-74 & n.3 (1st Cir. 2005). In the administrative law context, the "substantial evidence" standard for reviewing agency factual findings is even more deferential than the "clearly erroneous" standard of appellate review, *Dickinson* v. *Zurko*, 527 U.S. 150, 164 (1999), and it is satisfied if the evidence would justify, in a jury trial, a refusal to take a decision away from the jury, *id.* at 162; *NLRB* v. *Columbian Enameling & Stamping* Co., 306 U.S. 292, 300 (1939). And the "arbitrary and capricious" standard more generally requires only a "rational" foundation for the agency decision. See *Motor Vehicle Mfgrs. Ass'n* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42-43 (1983). Those standards are specifically identified in the Administrative Procedure Act itself, 5 U.S.C. 706(2)(A) and (E), and they reflect a special measure of deference rooted in the separation of powers and statutory allocations of governmental power. See, *e.g.*, *FCC* v. *Pottsville Broadcasting Co.*, 309 U.S. 134, 141 (1940).

ERISA's statutory cause of action to recover benefits under a plan does not incorporate those standards. It rather looks to the distinct body of private trust law, which imposes special fiduciary duties of loyalty, prudence, and care and assigns reviewing responsibilities to courts under a more general standard of reasonableness that traditionally has required especially careful scrutiny in the case of a self-interested trustee. There are other key differences between ERISA and the administrative law context. "Decisions in the ERISA context involve the interpretation of contractual entitlements; they are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers," and "the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies." *Brown*, 898 F.2d at 1564 n.7 (internal quotation marks omitted).

cessing regulations. Only under the meaningful yet flexible standard of review for reasonableness can the courts ensure that participants and beneficiaries receive the benefits they are due.

C. The Court Of Appeals Correctly Determined That MetLife Abused Its Discretion In Denying Benefits Here

The court of appeals in this case correctly determined that MetLife operated under a conflict of interest that should be weighed in reviewing MetLife's benefit determination. Pet. App. 9a-10a, 24a-26a. In addition, the court of appeals applied appropriately searching judicial review to conclude that MetLife abused its discretion in denying respondent's claim for benefits. *Id.* at 9a-10a.

The court of appeals had ample basis to closely scrutinize, and ultimately to overturn, MetLife's benefit denial. In addition to MetLife's inherent conflict of interest (Pet. App. 10a), which was fully implicated by a denial of permanent disability benefits, the court considered numerous other factors, such as MetLife's failure in its final decision to consider the award of Social Security benefits that it helped respondent obtain. *Id.* at 10a-11a, 14a-15a. The SSA determination was plainly relevant because the Social Security standard was more stringent than the plan's definition of disability, *id.* at 13a & n.1, and because respondent's condition remained essentially unchanged from the time of the SSA award to the time of MetLife's denial of benefits, *id.* at 3a-8a. Yet MetLife never even addressed it. *Id.* at 16a. Consistent with *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822 (2003), the court noted that, although the SSA determination was "certainly not binding," it was

also "far from meaningless." Pet. App. 15a (internal quotation marks omitted).

The court of appeals also noted MetLife's "inappropriately selective" analysis of the medical evidence, Pet. App. 9a-10a, 25a, which included its "persistent failure to give any weight" to the letters in which Dr. Patel "clearly stated that he did not believe [respondent] was capable of returning to work," *id.* at 15a. Instead, MetLife relied heavily on a two-page form where Dr. Patel checked "yes" to a question regarding whether respondent could work, despite the fact that that response "is so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational." *Id.* at 16a. MetLife "offered no explanation for its resolution" of that inconsistency in the evidence; indeed, it was unclear whether MetLife considered Dr. Patel's unequivocal conclusion at all. *Id.* at 20a.

Further, the court noted that MetLife chose to conduct a file review rather than have Dr. Pujara examine respondent and that MetLife apparently did not provide that reviewing doctor (or MetLife's occupational skills analyst) with the letters in which Dr. Patel stated unequivocally that respondent could not return to work. Pet. App. 18a-19a. And it observed that Dr. Pujara's conclusions were equivocal at best: indeed, he stated that "permanent disability can be considered" if respondent's job entails a "significant degree of emotional stress." *Id.* at 8a.

The court also pointed out that, "[d]espite the consistent and repeated references by Dr. Patel to stress as a factor in [respondent's] condition," MetLife concluded that there was "no supportive medical documentation" showing that her condition is exacerbated by stress, and

it provided no explanation for that conclusion. Pet. App. 21a-22a. The court recognized that, under *Nord*, MetLife was not required to "accord special deference" to Dr. Patel as respondent's treating physician, but that does not mean it could "arbitrarily repudiate or refuse to consider [Dr. Patel's] opinions." *Id.* at 19a, 23a-24a; see *Nord*, 538 U.S. at 834. Considering all of those factors, the court of appeals had ample basis on the record before it to conclude that MetLife's denial of benefits was outside the range of reasonableness and that respondent therefore is entitled to recover disability benefits under the plan.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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